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ABSTRACT

The New York City Department of Health (CDOH) traditionally has provided health care to the approximately one million students in New York City's public schools, but budget cuts have reduced its services substantially. Both the New York State Department of Health (SDOH) and New York City Board of Education (BOE) have been critical of CDOH's services and have created demonstration projects providing different levels and methods of school health care. The Health Section of Citizen's Committee for Children of New York, Inc. evaluated the three forms of school health service and prepared this report summarizing its findings. The report presents a brief history of school health services in New York City, describes the patterns of delivery of school health services, analyzes the level of services provided by the three agencies under review, and proposes a new model for school health services based on the two demonstration projects. Recommendations include a core program for all schools plus additional services in "high risk" (low income) districts. Estimates are given as to funding that would be required to support such a program. Appended to the report are (A) statistical information on existing school health programs; (B-D) descriptions of the CDOH school health program, the BOE demonstration projects, and the SDOH demonstration projects; (E) a matrix used by the SDOH to determine which City districts are "high risk"; and (F) a memorandum on differences between City and State projects in Community School District #4. (CJM)

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Rx FOR SCHOOL CHILDREN

AN OVERVIEW OF SCHOOL HEALTH PROGRAMS IN NEW YORK CITY AND RECOMMENDATIONS FOR CHANGE

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Rx FOR SCHOOL CHILDREN

AN OVERVIEW OF SCHOOL HEALTH PROGRAMS IN NEW YORK CITY AND RECOMMENDATIONS FOR CHANGE

A Report by

Citizens' Committee for Children of New York, Inc.

October 1983

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The School Health Subcommittee gratefully acknowledges the assistance of the Project Directors and District Supervisors and their staff who so willingly and enthusiastically gave of their time to meet with us. We also wish to thank the staff of the Board of Education, the New York City Department of Health and the State Department of Health for making the visits possible and for providing us with information about their programs. The responsibility for all opinions and statements contained in this Report is ours alone.

Special thanks go to Equitable Life Assurance Society for printing this report.

GLOSSARY OF FREQUENTLY USED ABBREVIATIONS

AAP	American Academy of Pediatrics
AFDC	Aid to Families with Dependent Children
BOE	Board of Education
CDOH	New York City Department of Health
CPR	Cardio-pulmonary Resuscitation
CSD	Community School District
NP	Nurse Practitioner
PNP	Pediatric Nurse Practitioner
PHN	Public Health Nurse
SDOH	New York State Department of Health

TABLE OF CONTENTS

		Page
	Acknowledgments	i
	Glossary	ii
I.	Introduction	1
II.	Summary Findings	3
	City Department of Health	3
	Board of Education	3
	State Department of Health	4
III.	Recommendations	5
	Program Model	5
	Estimated Cost and Funding	7
	Organizational Auspices	8
IV.	Methodology and Organization of the Report	10
V.	Recent History of the Provision of School Health Services in New York City	12
VI.	Patterns of Delivery of School Health Services	15
	Components of a School Health Program	16
	Staffing Patterns	19
VII.	Findings	22
	Relationships Among Agencies	22
	Health Aides	24
	Provision of Physical Examinations and Follow-up	25
	Quality of Care	27
	Staff Nurses	28
	Costs	29

APPENDICES

		Page
A.	Summary Characteristics of the School Health Programs	31
B.	Description of the New York City Department of Health School Health Program	32
C.	Description of the Board of Education Demonstration Projects	35
D.	Description of the State Department of Health Demonstration Projects	37
E.	State Department of Health Table Used to Determine Which School Districts are "High-Risk"	41
F.	Memorandum on Differences between City and State Projects in Community School District #4	44

I. INTRODUCTION

The provision of school health services to over one million children who attend New York City public and parochial schools has been the subject of debate recently. The controversy not only concerns which agency, the New York City Department of Health (CDOH) or the Board of Education (BOE), should coordinate these services, but also raises questions about the best way to deliver, staff and finance the program.

While the New York City Department of Health continues to be the official provider of school health services, both the New York City Board of Education and the New York State Department of Health (SDOH) have created demonstration projects in a number of community school districts. These projects have experimented with different levels of school health services and different methods of delivering those services to New York City's school age population.

The City and State funded demonstration projects thus offered an opportunity for the Health Section of Citizens' Committee for Children of New York, Inc. to assess a variety of approaches to the provision of school health services. CCC members visited the Board of Education and State Department of Health projects to determine what model for the delivery of school health services appears most appropriate for New York City school children and what level of service is required. For purposes of comparison, we also examined services currently being provided by the New York City Department of Health. We studied what effect the organizational auspices of the school health program has on the delivery of services.

In this inquiry, CCC was guided by the principle that all children need access to primary and preventive care of high quality. In a health care system where many barriers prevent families from obtaining such care, schools are the most likely places in which to ensure that health problems of school age children are identified and children are linked with appropriate providers. A partnership between the health care and education systems is needed.

The benefits of such a partnership are substantial. Many health problems affect a child's potential to learn, and the school system benefits from the resolution of these problems. At the same time, a responsive school health program can promote the appropriate use of the health care system by detecting health problems early and referring children to qualified providers. Just as important, the school health program can teach students about their own health and how to make appropriate use of health care resources.

This report discusses our findings on the programs we visited and makes recommendations for improving the City's school health services so that they will more effectively promote the health and well-being of school age children.

II. SUMMARY FINDINGS*

City Department of Health

Citizens' Committee for Children found that the relationship between the Department of Health's school health program staff and the Board of Education staff in the schools is too often based on mistrust, and that this lack of cooperation between the agencies is an impediment to the development and implementation of an effective school health program.

One of the primary causes of the poor relationship is the lack of visibility of the CDOH program in the schools, which is exacerbated by the recent reduction in the CDOH school health staff. The Department is performing new admission examinations to those students who do not have an outside provider, providing follow-up and referrals, and teacher-nurse and faculty-nurse conferences. CCC found that while the CDOH has taken positive steps to reorganize its school health program, the current staffing level of one nurse for every 6-7,000 children is grossly inadequate. The lack of a full-time health presence in the school affects the ability of the CDOH nursing staff - already overburdened - to insure appropriate follow-up and referral. Board of Education teachers, principals and administrators as well as State Department of Health project staff whom we interviewed believe that the CDOH program does not meet the needs of New York City's children for school health services, and both agencies are ready to play a role in filling a vacuum.

Board of Education

While the Board of Education model for the delivery of school health services - offering height, weight, vision and hearing screening, follow-up and referrals, and ensuring that physical examinations are performed - appears to be effective in middle class school districts where most children have primary care providers, it is less successful in meeting the needs of low-income students who are not linked

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* A complete discussion of the findings of this report is in Section VII.

with private physicians or clinics. In its demonstration projects, the Board of Education has made certain that first aid problems are managed and that teachers and principals are relieved of the responsibility of supervising sick children by stationing a full-time health aide in every school. However, the lack of adequate medical supervision of the BOE program limits the ability of the project staff to ensure that a child receives appropriate and ongoing care.

State Department of Health

The State Department of Health projects, in contrast to both the Board of Education projects and the City Department of Health program, offer those children lacking a source of medical care the opportunity to receive comprehensive treatment in the school from a primary health care provider in the community. CCC found this opportunity to be the model's major advantage, since the provider for the project becomes the child's case manager and can treat the child at school or in the clinic. In addition, the State projects are more staff-intensive than either the BOE projects or the CDOH program.

III. RECOMMENDATIONS

Program Model

CCC believes that New York City should use the experiences of the State DOH and BOE demonstration projects as a basis for developing a more effective citywide school health program. Central responsibility for the new program should rest with one City agency. The program should contain the following elements:

1. A core program should be developed and provided in all schools. This program should ensure that all children receive the following services:

   a. First Aid

   b. Height, Weight, Vision and Hearing Screening

   c. Physical Examinations

   d. Follow-up and Referral

   e. Dental Screening and Referral

   f. Health Counseling and Guidance

2. This core program is sufficient for the 22 community school districts in which it is reasonable to assume that children commonly have primary care providers.* First aid and screenings should be performed in the school by health aides. Public health nurses or pediatric nurse practitioners (NP) should provide follow-up and referrals. New Admission physical examinations should be administered by the child's private physician or clinic and school health staff should work with the provider to ensure that children receive care of good quality. If a child has no source of primary care, New Admission examinations should be performed in the school by a pediatric nurse practitioner or physician. Pediatricians should work as consultants to the pediatric nurse practitioners and supervisors to the school health staff. A

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* The State Department of Health has examined socio-economic indicators and health status to determine which community school districts are "high-risk" areas where it is assumed that children do not have primary care providers and therefore need comprehensive services in the school. The Department identified ten "high-risk" districts. It is assumed that in the other 22 districts, children commonly have providers.

school health program based on the Board of Education project model would satisfy these standards if adequate pediatric supervision were assured.

3. A core program plus treatment in the schools should be provided in every school district where children do not commonly have access to a regular source of health care and where school health services may represent their only opportunity to receive health care. The SDOH has identified 10 such districts. In these "high-risk" school districts, nurse practitioners and pediatricians should become the child's case manager for acute care and chronic illnesses and a program modeled on the State Department of Health projects should be implemented.

4. In the 22 community school districts receiving only the core program, the following staff should be employed:

a. One health aide for every school with more than 750 students

b. One part-time aide for schools under 750 students

c. One public health nurse or pediatric nurse practitioner for every 4,000 students*

d. One part-time pediatrician for every 13-14,000 students

e. One dental hygienist for every 5,000 students (two visits per child per year)**

5. In the 10 "high-risk" school districts receiving more comprehensive services, the City should employ:

a. One health aide for every school with more than 750 students

b. One part-time aide for schools under 750 students

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* If the program relies only on public health nurses, the project should employ a pediatric nurse practitioner to assist the pediatricans in performing the examinations.

** Access to dental services is poor throughout the City, regardless of whether children live in "high-risk" or "low-risk" school districts. (See text, p.19). Therefore, one dental hygienist for every 5,000 students is appropriate for all districts.

c. One pediatric nurse practitioner for every 1,000 students

d. One part-time pediatrician for every 5,000 students

e. One dental hygienist for every 5,000 students (two visits per child per year)

Estimated Cost and Funding

The core program would cost approximately $29 per student. This figure is based on the costs associated with the BOE project in CSD #4, plus the cost of hiring a full-time dental hygienist for every 5,000 students.*

To implement the more intensive model, it is estimated that the City would need to spend about $55 per student. This estimate is based on the program costs of the SDOH project in CSD #4, plus the costs associated with the dental hygienist.** The precise cost will vary depending on the salary levels of the staff employed in the program.

Implementing the core program in 22 districts would cost about $20.7 million. The cost of implementing the intensive program in 10 "high-risk" school districts would be about $9.6 million.*** The total cost for the 32 school districts would be approximately $30.3 million

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* The cost of one full-time project director, one full-time clerical worker, four pediatric nurse practitioners, 20 health aides, one part-time pediatrician plus equipment in CSD #4 in the 1982-83 school year for 13,500 students was $352,000 or $26 per student. The costs of the dental hygienists were determined by multiplying the annual salary ($17,200) by the 2½ full-time hygienists necessary for 13,500 students. The total cost of this program for 13,500 thus equals $395,000 or $29.25 per student.

** The cost of the SDOH project in CSD #4 includes one full-time project director, 5 health aides, 5 mid level practitioners, one part-time pediatrician, one secretary, one part-time billing clerk (for Medicaid), one full-time community organizer, plus equipment and supplies. This cost was $256,000 in the 1982-83 school year. We have added $17,200 for the dental hygienist. The cost for this intensive program is now $273,200 for 3,162 children or $86 per child in CSD #4. Based on the model we recommend (one NP for every 1,000 students) the cost per child would be $55 in the "high-risk" districts.

*** The New York City Department of Health estimates that there were 899,994 public and parochial elementary and junior high school students registered in the 1982-83 school year. In the 22 districts there were 714,757 students, with 175,237 students in the 10 "high-risk" areas.

Currently, approximately $14 million is spent on school health services in New York City.* The cost of the enhanced school health program we propose is justified by the benefits that will flow to both the school system and the health care system. With an improved school health program fewer children will require treatment in expensive hospitals and clinics. At the same time, better management of health problems will keep more children in school, thus reducing the City's lost revenue from the State because of student absences.**

To permit the gradual assumption of the increased costs we would recommend that the enhanced citywide program be phased in gradually. The first phase should be the implementation of the core program in all 32 school districts, at a cost of $26 million. In the following year the City should implement the intensive program in the 10 "high-risk" districts.***

We recommend that both the City and State participate in meeting the additional costs of this enhanced program.

Organizational Auspices

In the past, Citizens' Committee for Children has always favored administration of the school health program by the New York City Department of Health. At this time, we reserve final judgement on which City agency should administer the school health program we recommend above. If the CDOH continues to operate the program, it must

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* In City fiscal year 1982, expenditures for the NYC DOH's School Health program totaled about $11.7 million from City and State funds, exclusive of dental care. The BOE contributed about $775,000 for its demonstration projects in 1982, and the State spent $1.8 million for its own demonstration projects. Medicaid reimbursements provide additional financial resources to these projects.

** The schools are reimbursed by the State on a per diem basis for the actual student attendance rather than student enrollment.

*** We assume that the SDOH school health demonstration projects in existence now in five "high-risk" districts would continue to be funded by the State so that students in some of the "high-risk" districts in the City will receive the intensive program of services.

receive sufficient budgetary support to hire health aides for every school and to increase the number of public health nurses or pediatric nurse practitioners to one nurse for every 4,000 students. Dental clinics of the Bureau of Dentistry should run at full capacity. In the school districts that require a more intensive program, the CDOH should either provide screening, examinations and treatment itself or contract with a neighborhood health center or hospital to provide these services in the schools.

If, on the other hand, the BOE were to take over responsibility for school health services, it would have to ensure that the entire program receives real medical supervision. In addition the BOE would have to set up methods of furnishing care to children in the parochial schools and providing examinations and treatment in "high-risk" community school districts.

Regardless of which City agency carries the responsibility, the program should be under the direction of a medical professional, not an educational administrator. In addition, a Coordinating Council on School Health with representatives from the Chancellor's office at the Board of Education and the Commissioner's office at the City Department of Health should be established to oversee the school health program. This committee would meet to review the progress of the program and would take the initiative in seeking joint solutions to problems that arise in the implementation of the program. A representative of the Mayor's office should assume responsibility for directing the work of the Coordinating Council to ensure that both agencies collaborate in the development of the program. Representatives from nongovernmental agencies with an interest in school health might be included on the committee. With a small budget this committee could issue an annual report on the status of the program.

In each school district the district health staff and the community school board should devise their own coordinating mechanisms to assure cooperation among school and health staffs, parents and health care providers.

IV. METHODOLOGY AND ORGANIZATION OF REPORT

Between April and June, 1983, members of the Health Section of Citizens' Committee for Children visited the three Board of Education (BOE) projects and six of the seven State Department of Health (SDOH) projects in New York City. In order to assess the quantity and quality of services being provided to students in schools in which no demonstration projects exist, CCC also visited two school districts receiving school health services from the City Department of Health (CDOH).*

We conferred with project directors, medical supervisors, nursing staff, health aides, principals and teachers in schools participating in the demonstration projects. We also consulted CDOH School Children's Health Program staff, SDOH administrators and BOE employees to learn their views on school health and on the demonstration projects. We studied reports on the SDOH and BOE projects, and we visited the Robert Wood Johnson Foundation project in Newburgh, N.Y. on which the State projects are based.

The following issues were discussed during the site visits:

1. the socio-economic status and health status of children in the neighborhood and the availability of health care providers in the neighborhood
2. the number and level of staff employed and the number of children being served in each project
3. the kinds of services being provided
4. the relationship of the project staff to the following:

   the teachers and principals in the school,
   the community school board and superintendent,
   the NYC DOH school health and district staff,
   community and parent groups

5. the cost of the project

Organization of the Report

The report that follows presents first a brief history of the provision of

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* A full description of these programs is included in Appendices B-D.

school health services in New York City. We then examine different models used for the delivery of these services. Taking the American Academy of Pediatrics report on school health as a guide, we compare the New York City Department of Health school health program, the Board of Education demonstration projects, and the State Department of Health projects as to the kinds of services each agency has provided in its program and how it has staffed them. In Section VII we assess some of the differences among the models, an analysis that is the basis for our recommendations in Section III on how school health services should be improved.

V. RECENT HISTORY OF THE PROVISION OF SCHOOL HEALTH SERVICES IN NEW YORK CITY

Once one of the best in the country, the school health program under the auspices of the New York City Department of Health (DOH) has suffered budgetary cutbacks in the last decade that have severely reduced the level and quality of services being provided to school age children. Between 1970 and 1980 these cuts resulted in a 50% decrease in clinical and supervisory physician time. Only one physical examination (at school entry) is now required compared to four in grades K-12 prior to 1975.*

In 1981, the Board of Education (BOE), critical of the paucity of health professionals in the schools, urged that the City allow it to take over the school health program. The Report of the Chancellor's Task Force on School Health recommended that the provision of basic school health services be the permanent responsibility of the New York City Board of Education.

In its 1982 New York City Budget request, the BOE asked for $11 million to implement a school health program based on the findings of its report. Although the City did not fund this request, several City officials involved in the budget process acknowledged that the DOH was not providing adequate care. The BOE, meanwhile, continues to be critical of the services offered to its students.

In the midst of the competition over which agency should run the school health program, there has been a proliferation of demonstration projects throughout the City that have experimented with various service and delivery models. In 1981, as the result of a joint effort by the minority caucus of the New York State Legislature and the State Department of Health (SDOH), health care providers in seven low socio-economic school districts entered into contracts with the SDOH to provide health

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* From: NYC DOH, "Promoting Health in Schools: A Review and Plan for Action for New York City," July 1981.

services in the schools.* These services include the provision of a complete physical examination, vision and hearing screening, immunizations and first aid as well as the option of receiving comprehensive primary health care in the schools. A 1978 New York State law allows the Article 28 providers to collect Medicaid reimbursement for those services provided in the school to Medicaid-eligible children.**

Meanwhile, the Board of Education implemented demonstration projects of its own in three community school districts in New York City. Instead of providing direct services in the schools, this model concentrates on ensuring that children in the schools receive required screenings, and that new students, 3rd and 7th graders and children in special education receive examinations. The BOE projects, like the SDOH projects, place a full-time health aide in every school so that all children can receive first aid.

The Health Section of Citizens' Committee for Children has long been interested in school health. In 1974 the Committee released its report, CHANGE IS OVERDUE, which criticized the services provided at that time by the CDOH. The report urged the Department to move away from in-school examinations and concentrate more on liaison with outside providers and follow-up services to ensure that children actually receive care. Since that time, the services offered by the Department have deteriorated even further, largely due to budget cutbacks in the entire department after the NYC fiscal crisis.

CCC continues to be concerned about school health services. We have followed the quality of the services provided by the CDOH and have pressed every year for increases in the City budget to fund improvements in the program. At the same time,

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* Chapter 50 of the laws of 1981 enables the SDOH to develop 9 demonstration projects: one each in Rochester and Buffalo and seven in New York City.

** "Article 28 providers" are clinics, hospitals, doctors offices, etc., which are licensed by the SDOH to provide health care services under Article 28 of the New York State Health Law. The providers need the 1978 waiver provision in order to collect from Medicaid because without it, Article 28 providers may not collect reimbursements for services delivered in the schools since the schools are not included on the list of approved sites on their Article 28 certificates.

we have analyzed the Chancellor's Report on School Health and have questions about the way in which it proposes to deliver services. But while we see inadequacies in both the CDOH program and the BOE proposal, we have not reached a conclusion on which agency should coordinate the program. In our view, placing the program under the auspices of a different agency will not necessarily improve the quality of the services being provided to the school children. What is needed is a new plan for the delivery of school health services and a commitment on the part of City and State officials to fund a program that can meet the needs of all the City's children.

VI. PATTERNS OF DELIVERY OF SCHOOL HEALTH SERVICES

The Board of Education (BOE) and State Department of Health (SDOH) demonstration projects and the New York City Department of Health (CDOH) school health program use a variety of service-delivery models. The ability of any school health program to meet the health needs of school age children is determined in part by the number and type of staff it employs and the functions and responsibilities assigned to them. In addition, school health programs differ in their basic objectives, that is, in the level of service they seek to provide.

The American Academy of Pediatrics (AAP) identifies two models for the delivery of school health services.* The first, the "school health program," is concerned with the "prevention, identification, observation and management of health problems in the school setting." Children in these programs receive medical and dental screening, immunizations, and first aid, in addition to health education and health promotion.

When health problems are identified in a "school health program," school health staff (health aides along with public health nurses and/or pediatric nurse practitioners)refer the children to outside physicians for diagnosis and treatment. This program assumes that children have a regular source of medical care and encourages cooperation among staff, parents and health care providers in order to facilitate treatment. The New York City Department of Health School Children's Health Program and the demonstration projects implemented by the Board of Education are examples of this type of school health service.

A second model for the delivery of school health services is the "health program in the school." In areas where there are few clinics or doctors, or in communities where children, for whatever reason, do not have access to the health care system, a health care program in the school may represent the only available source of health

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* American Academy of Pediatrics, School Health, A Guide for Health Professionals, 1981. The standards for school health programs outlined in this section are largely from that guide.

care. In these schools, children have the option of receiving screening, preventive services and primary care treatment in the schools free of charge. These projects rely on nurse practitioners to provide services and may receive third party reimbursement (Medicaid) for funding.*

The New York State Department of Health uses the "health program in the school" approach for its school health demonstration projects. Children in schools participating in the State projects have the option of signing up for three levels of care:

1. Usual health services, which entitles children to receive screening (height, weight, vision and hearing) and first aid

2. Usual services in addition to a complete physical examination for new admissions, third and seventh graders. The examination includes immunizations (when incomplete)and laboratory tests (hematocrit, urinalysis and tuberculosis testing)

3. Complete comprehensive treatment by the Article 28 provider either in the school or at the Article 28 facility. The Article 28 provider becomes the child's primary care provider.

Components of a School Health Program

Both types of program should ensure the receipt of certain services that are necessary to promote the health of the school age child:

1. First Aid

Someone on the school health staff should be assigned to respond to minor bumps and bruises and first aid problems. In the City Department of Health program, teachers and/or principals in the schools are responsible for responding to these problems on a daily basis. When available, CDOH school health nurses will handle emergency problems. The Board of Education and the SDOH projects rely on the presence of full-time health aides to administer first aid. In the SDOH project, in addition to the health aide, nurse practitioners often treat children who are in need of first aid.

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* The Robert Wood Johnson Foundation has provided grants to a number of cities including Newburgh and Norwich, N.Y. for school health demonstration projects which test this model. See the Robert Wood Johnson Foundation Special Report; School Health Services, November 1, 1979.

2. Height, Weight, Vision and Hearing Screenings

Screening can lead to early detection and treatment of disease if there is adequate follow-up. Height, weight, vision and hearing screenings are done annually by the classroom teachers in schools receiving health services from the CDOH. In the BOE and SDOH projects health aides perform the screenings.

3. Physical Examinations

The importance of the physical examination is in the early identification of health problems and the opportunity to provide remediation. Physical examinations are best performed by the pediatrician or pediatric nurse practitioner (PNP) responsible for the child's health care. If a child has no regular source of care, the M.D. or PNP can provide the examination in the school. Every attempt should be made to inform the parent when the examination is scheduled so that s/he may be present to talk to the health professional about the child's medical history. According to the AAP, the frequency of physical examinations should be determined by the local health department, although the AAP identifies the following as the order of priority for medical appraisal:

1. Children identified as having problems
2. New Admission students
3. In midschool (6th or 7th grade)
4. Before leaving school (11th or 12th grade)

Prior to the fiscal crisis, the New York City Department of Health provided four physical examinations: for New Admission students and 3rd, 7th and 12th graders. Now the department performs examinations for new students only. Both the BOE and the SDOH demonstration projects call for examination of New Admissions as well as children in 3rd and 7th grade and in special education classes.

In the CDOH program, physicians or pediatric nurse associates perform physical examinations in the schools for those children who fail to return a signed medical

form.* Students in BOE projects who fail to return a completed form are given an examination by nurse practitioners or in one project by CDOH doctors or nurse practitioners. Pediatric nurse practitioners in the SDOH projects perform physical examinations for those children who sign up to receive services in the school.

4. Immunizations

Immunizations should be performed in the pre-school years and the school health program should ensure their completion. The CDOH no longer provides immunizations in the school. Those with incomplete records of immunizations are referred to the department's District Health Centers. In the BOE and SDOH projects, immunizations are performed for those students who have not received them.

5. Follow-up

Follow-up is vital for the effectiveness of the school health program. This service includes interpretation of the health problem to parents, teachers and the medical professional who is the child's regular source of health care.

All records of physical examinations, whether performed in the school or by private providers, should be reviewed by the nurse practitioner or public health nurse assigned to the school to determine which children are in need of follow-up. The results of screening tests should also be reviewed by the nurse. If a parent is not present when the examination is performed, the aide and the nurse are responsible for informing the parent of a potential health problem and making sure that the child gets the appropriate treatment. There should be some system in place to confirm the family's compliance with the referral.

In the CDOH program, public health nurses are responsible for follow-up. Nurses in the program make limited home visits to ensure that a parent has secured medical care for an identified health problem. In the BOE projects, nurse practitioners

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* The New York City school system requires children to return the 212s form completed by a private physician or clinic to show that a child has a private source of medical care. This information is recorded on the 103s form used throughout the City which is the child's permanent medical record and travels with the child as s/he moves from school to school.

and public health nurses provide follow-up. In the State projects, nurse practitioners or physician assistants are responsible for this service.

6. Dental Program

Dental caries is the most prevalent chronic disease affecting children today. In New York City, 68.2% of children in grades K-9 reported receiving no dental care in the 1982-83 school year.* Dental screening and referral for treatment must be part of a school health program. All children should be screened for dental problems. Follow-up and referral are critical. In all the BOE demonstrations and in some of the State projects, a system has been set up whereby aides call dental clinics to set up block appointments for children. School buses have been made available for transporting children to the clinics during school hours. CSD #18 in Brooklyn offers an example of a successful program.

Any dental services furnished by the CDOH are part of the Bureau of Dentistry and are separate from the DOH school health services. Beginning in the 1983-84 school year, the Bureau of Dentistry will resume sending dental hygienists into the schools to perform dental screenings and refer those in need of care to CDOH dental clinics and private providers. In addition the Bureau of Dentistry operates 84 school based dental clinics; however, many are staffed only one day a week.

Staffing Patterns

The following combination of health professionals and paraprofessionals plays a role in the provision of school health services:

1. Doctors

Every school health program should have an M.D. as its director. In addition, either a pediatrician or a family practice physician should supervise the school health program in a group of schools. The responsibilities of the physician should

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* Source: Dr. Yale Pava, Director, Bureau of Dentistry, CDOH. Prior to the 1975 fiscal crisis, 174 dental hygienists worked in the schools examining children who reported receiving no care. Funds provided to the CDOH in the 1983 budget will allow the Department to send 44 full-time hygienists into the schools.

include planning and supervising the first aid and emergency care procedures and the procedures for physical examinations and follow-up. S/he should also be involved in the training of the health aides. In addition the M.D. should be available to perform examinations and for consultation in the management of health problems identified by staff.

2. Nurses

Public health nurses and pediatric nurse practitioners should be responsible for the early detection and correction of health problems identified through screening, immunizations, and the physical examination as well as through teacher-nurse conferences. The public health nurses in the program should review all the medical records of those children who have health problems and need follow-up care. Nurses should communicate with parents, teachers and doctors about the need for referral and treatment and should work with them to assess and arrange appropriate management and referral of problems. Nurses should also supervise screenings and first aid procedures performed by the health aides. In addition, pediatric nurse practitioners can conduct medical examinations and treat those children who are receiving services in the school.

3. Health Aides

The presence of a health aide in each school can relieve teachers and principals of responding to first aid problems. Aides also relieve nurses of performing routine procedures and allow them more time for follow-up and referral.

Aides are responsible for keeping medical records up to date and telephoning parents in addition to caring for minor injuries. Aides can also be trained to perform vision, hearing, height and weight screening.

The New York City Department of Health relies on supervising public health nurses to oversee the school health program and on physicians and pediatric nurse practitioners to perform the physical examinations. There are 15 M.D.'s supervising members of the staff who perform examinations. Public health nurses provide follow-up

and do home visits. There are no health aides in the CDOH program. However, public health assistants - trained to assist in the physical examination in addition to maintaining records - help the public health nurse keep the medical records up to date. There is approximately 1 nurse per 6,000-7,000 children in the CDOH program.

The Board of Education school health projects are supervised by an educational administrator, not a health professional. In 2 projects pediatric nurse practitioners perform the physical examinations. In the third, examinations are given by CDOH physicians. Public health nurses or the nurse practitioners furnish the follow-up care. There is approximately 1 nurse providing services for 3,000-6,000 children. Each project school has a health aide performing first aid and maintaining records.

Physicians working from the Article 28 providers direct the SDOH projects, and they and the nurse practitioners examine and treat children who choose to receive health care in the school. Physician assistants work in some of the projects in lieu of nurse practitioners. There is usually a nurse practitioner or physician assistant providing services, along with a health aide, in every school.

VII. FINDINGS

Relationships Among Agencies

The apparent mistrust between the New York City Department of Health (CDOH) on the one hand and the Board of Education (BOE) and State Department of Health (SDOH) at the local level on the other hand has impeded the ability of the sponsor of a school health demonstration project to successfully implement it.

In almost every school district CCC visited, project staff expressed frustration when discussing their relationships with the New York City Department of Health's School Health Program. Project coordinators stated that CDOH staff felt defensive about being removed from the schools in the project districts and have been reluctant to assist in the development of the programs or in their implementation. While some CDOH school staff had instructed project personnel in the use of the medical forms, one project coordinator stated that the CDOH provided "nothing but forms."

SDOH project staff, as well as their BOE counterparts, were critical of the services previously furnished by the CDOH staff and appeared only too glad to have them removed from the schools.

The distrust among the agencies stems, in part at least, from the reduction in the services offered by the CDOH over the past ten years. Many project directors we interviewed stated that their projects had to make up for "years of neglect."

CDOH staff, on the other hand, believe their mission and that of the CDOH school health program is misunderstood. According to CDOH school staff we interviewed in Brooklyn, school administrators want a full-time nurse in every school to provide first aid. Teachers are critical because there are not enough nurses to go around. CDOH staff states that the role of the nurses is to provide casefinding and follow-up and to ensure receipt of medical services, not to administer first aid. CDOH staff acknowledge, however, that cutbacks in the department have forced children to see nurses less frequently and have required teachers and principals to spend more time attending to first aid problems.

For the CDOH staff, obtaining cooperation from the BOE staff in the handling of records was also a problem. A health aide in each school could alleviate both of these problems. However, CDOH staff thought that if the assistant was a BOE employee, problems of inter-agency coordination would continue.

While this competition exists between the school health staffs of the agencies, BOE and SDOH staff appear to work well with CDOH employees in the District Health Centers within their community school districts. Most demonstration projects refer children to the District Health Center dental clinics.

The BOE project in CSD #17 is an exception to the poor relationship between the CDOH and the BOE. This project is a collaborative model using BOE nurses and aides and CDOH school health doctors. The BOE staff seem sincere in their efforts to work cooperatively with the Health Department at all stages of their projects. CDOH district nurses provided in-service training for CSD #17 nurses. The latter follow Health Department procedures, use CDOH doctors to provide examinations and make full use of the CDOH services in the neighborhood. However, the Health Department did not participate in the planning of this project and the project coordinator spent a lot of time "selling" the BOE task force plan to the CDOH.

In the BOE projects, the relationship between the school administration (teachers, principals and school board) and the BOE school health staff appears to be excellent, since both are part of the same organization. The project director in CSD #18 has been active in school health for over 10 years, and his continued presence in the schools has facilitated the working relationship between project and school staff. The coordinators in CSD #4 & #17 have always been BOE employees. The presence of a full-time health aide who provides first aid is very popular with the administration of any school.

SDOH project staff had to work with and receive an endorsement from the community school district superintendent and the local school board before they could receive

funding from the SDOH. This collaboration facilitated their entrance into the schools and contributed to positive working relationships with most teachers and principals. In all school districts involved in the SDOH projects, teachers, principals and parents were familiar with the Article 28 facility providing the services. In a few districts the relationship among the school staff, parents and the provider was enhanced because the Article 28 facility is the only provider of ambulatory care in the neighborhood. Most teachers and principals appeared to be relieved that their pupils and their school would be receiving services from a full-time health team.

Health Aides

The health aides in the Board of Education and State Department of Health projects ensure there is a full-time health presence in the school to handle first aid.

The health aide is the central figure in the BOE projects. Aides serve as the link between children and the nurse practitioner as well as between children and teachers, their parents and health care providers. For example, the health aide might be the first person to identify symptoms of poor health. The aide is responsible for informing the public health nurse or nurse practitioner, who then may treat a child for minor illnesses or, most likely, refer the child to a provider within the community. The health aide follows up to ensure that the child is under care. In many cases, the health aide will accompany the child to the provider if the parent is unable to make the trip. Height, weight, vision and hearing screening is also the responsibility of aides.

The aides play an important part in handling records and in relieving teachers and principals of the responsibility of deciding what to do with a sick child. Their presence allows nurses to spend more time on follow-up and counseling.

Training for BOE health aides includes first aid and CPR, and in one project they are chosen from among parents who are active in the community. However, one BOE project coordinator expressed concern about civil service regulations that

prevented him from firing aides when he was dissatisfied with their performance.

In the SDOH projects the aide is important in staffing the medical room, providing first aid, performing screenings, and keeping records up to date. More health experience is required of the SDOH aides than of the BOE aides and the salary scale is higher. In some SDOH projects retired nurses have been hired as aides.

In the CDOH program, the lack of a health aide requires that teachers and principals attend to sick children, and it has contributed to the perception held by many BOE staff that the "CDOH is never there."

The CDOH believes strongly that first aid should not be the responsibility of its professional nursing staff. District nurses whom we interviewed in Brooklyn believed that trained aides could competently provide first aid and render much needed assistance in maintaining records. Their presence would alleviate some of the friction between the CDOH and the BOE staff who want school health staff in the schools full-time to respond to the health needs of children. If adequately trained, aides in the CDOH program could perform screenings.

Provision of Physical Examinations and Follow-up

The ability of school health staff to ensure that children receive physical examinations and adequate follow-up is affected not only by the staffing arrangements in the school but also by the socio-economic status of the community school district and the availability of health care resources in the area. For example, in the BOE project in CSD #18, a middle-class neighborhood, there is one nurse practitioner who is responsible for the more than 6,000 students receiving care in the project schools. Since most children in that district appear to have private physicians, few children depend on the nurse practitioner for examination.

In the 1982-83 school year in this district, 95% of the students mandated to receive examinations obtained them because the project coordinator successfully demanded that parents take their children to private physicians or clinics. The

nurse practitioner was able to concentrate on follow-up and referral. For this neighborhood a staffing ratio of 1 nurse practitioner for 6,000 children appears to be appropriate.

In school districts in poorer neighborhoods like CSD #4 and #17, more children rely on the school health staff to provide examinations. As a result, fewer examinations have been completed. In CSD #17 CDOH doctors perform 12 examinations per session and there are between 7 and 10 sessions per month. School health staff felt a need for more physician time to handle the large number of children who request examinations. In addition the ratio of 1 public health nurse for 4,900 students seems low given the need of students for follow-up care.

When compared to the BOE projects, the SDOH model is more staff intensive. In the community school districts served by the State project, all of which are poor neighborhoods where many children do not have private physicians, there is on average one mid level practitioner* for every 1,000 students. The medical room is staffed by both a health aide and a mid level practitioner. Yet in these projects many children are not receiving physical examinations. It is the first time that these children have had full-time health workers in the school every day, and many children avail themselves of the opportunity to get medical attention. In several of the schools we visited, nurse practitioners were providing first aid and treatment for minor illnesses in addition to and occasionally instead of examinations and follow-up.

In the CDOH school health service, physicians and pediatric nurse practitioners perform physical examinations in the schools for the New Admission students who request them. Public health nurses - approximately 1 for every 6,000-7,000 children - provide follow-up care. CDOH staff whom we interviewed in Brooklyn thought that this ratio is not realistic. In their opinion 1 nurse for every 5,000 students would

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* Mid level practitioners are either nurse practitioners or physician assistants whose responsibilities in the SDOH projects include physical examinations, treatment and follow-up care.

allow them to offer better services.

Quality of Care

Good medical supervision is crucial in order to promote the quality and continuity of care which is the chief objective of the school health program. With the exception of CSD #4, the BOE projects do not rely on direct supervision by a physician. In CSD #18, the Chief of Pediatrics at Kingsbrook Jewish Hospital serves as the nurse practitioner's preceptor. Although the doctor is listed as the supervisor of the program, it does not appear that she provides regular supervision. She does offer consultation to the nurse practitioner when the nurse has a problem. Kingsbrook Hospital is not itself considered as a back-up for the project.

The physicians in the project in CSD #17 are CDOH doctors. These doctors perform physical examinations of those children who cannot afford to pay for an outside provider but they do not assume responsibility for the project or its overall goals, in part perhaps because they are CDOH employees working in a BOE project.

In contrast, the CDOH has 15 full-time M.D.'s acting as supervisors for the physicians and nurse practitioners administering the physical examinations in its program. The State projects have part-time pediatricians from the Article 28 facilities who provide daily supervision and training for staff in addition to performing some of the physical examinations.

The need for continuity of care is most easily met in the State demonstration projects. The child seen in the school by the nurse practitioner is referred for follow-up to the Article 28 provider who has contracted with the school to provide primary care services. The physician in the school also works at the Article 28 facility and can treat the child at both the school and clinic sites. However, some children do not sign up to receive Level 3 services (comprehensive care). The project model assumes that these children have a primary care provider. Yet one could suspect from our discussions with project staff that many of the children whose

parents have not enrolled them for comprehensive health services are the ones that need the care the most. For these children, as well as the children in the BOE projects and the CDOH school health program, it is often not possible for the school health program to ensure continuity of care or to determine the quality of care being provided by the child's physician or clinic. In order to promote continuity of care it is necessary for school health staff to establish contact with the child's primary care provider and maintain a continuing relationship with that provider. School health staff should also develop sources of care to which children lacking a provider can be referred.

In the BOE project in CSD #4 (East Harlem), the staff has established a District Policy Advisory Board composed of administrators from the clinics and hospitals in the neighborhood and the school health staff. The Advisory Board discusses health related problems specific to CSD #4 schools and the providers who serve the neighborhood and strengthens the relationships between teachers, principals and school health staff and the providers to whom they refer. In CSD #17, an area with limited health care resources, the school staff has worked out an arrangement with doctors in the community who now examine children of the project schools in their offices on a sliding fee scale.

Staff Nurses

Pediatric nurse practitioners are employed in the SDOH projects, the BOE projects in CSD #4 and #18 and in a few of the schools served by the New York City DOH school health program. Pediatric nurse practitioners, also known as pediatric nurse associates, are registered nurses who have a bachelor's degree in addition to having completed either a master's program or a certificate program with clinical training in pediatrics. Pediatric nurse practitioners can perform duties directly related to patient care. They are skilled in physical examinations, diagnosis and treatment of common pediatric ailments, and health.

Physician assistants are working in some of the SDOH projects in lieu of pediatric nurse practitioners. Physician assistants' training programs vary in length from 12 months for students with prior health care experience in the Armed Forces to four years. Physician assistants can also perform physical examinations and provide referral and follow-up, yet few of them have had training in pediatrics. Many of the State project coordinators to whom we spoke found that they could recruit physician assistants more easily than pediatric nurse practitioners, although they prefered the pediatric nurse practitioner because of her pediatric training.

In the BOE project in CSD #17 and in the CDOH school health program, public health nurses are employed to provide follow-up care and referral. Public health nurses are registered nurses with additional public health training. Public health nurses are appropriate for school health programs that provide follow-up, referral and health education and counseling in addition to screening. They cannot, however, perform physical examinations.

Costs

The cost of the BOE projects varies depending on the personnel employed.* The CSD #18 project costs $125,000, approximately $19 per child. In CSD #17 the costs are lower ($297,000 or $12/child) and in CSD # 4 they are higher ($350,000 or $25 per child). Funds are for staff costs only. Equipment is paid for out of the individual principal's budget or by special grants. CSD #17 clearly needs more money for the purchase of supplies and forms and the maintenance of equipment. We heard many complaints about the condition of the audiometers used to give hearing tests.

The SDOH model is more expensive than the BOE projects but reflects the cost of providing complete comprehensive care which the BOE projects do not offer. State

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*The CSD #18 project, with 1 nurse practitioner, is less expensive than CSD #4 because CSD #4 employs NP's and a pediatrician. CSD #18 has no physician on staff. It consults with a M.D. at Kingsbrook Hospital. CSD #17 receives less money than CSD #4 and 18 because public health nurses are employed instead of nurse practitioners (the PHN's salary is lower) and DOH pays for the salaries of the doctors providing care.

project costs vary between $50 and $100 for the child who is receiving Level 2 or 3 care. The State DOH provides a $200,000 grant for personnel to each project. Projects are also supported by private funding sources and in-kind contributions from the Article 28 provider.

Through a 1978 New York State law, the Article 28 provider in the SDOH demonstration projects can collect Medicaid reimbursement for services delivered in the schools. However, only physical examinations and follow-up visits are billable services and the rates are quite low.* Programs cannot bill for first aid screenings, immunizations or counseling. Thus the revenue received by each project from Medicaid is a very small percentage of the total budget. In addition, on average only 50% of the children enrolled in Levels 2 and 3 are Medicaid-eligible. The State has made no provision for the cost of comprehensive care to the medically indigent.

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*$26.20 for a complete physical, $17.50 for a follow-up visit. Ambulatory care clinics are reimbursed $60.00 for examinations provided in the clinic.

SUMMARY CHARACTERISTICS OF THE SCHOOL HEALTH PROGRAMS

Program		CSD#	# of Schools	Public Schools	Parochial Schools	Total Student Population	Total Enrollment[a] #	%
DOH:	School Children's Health Program	15 & 20	84[d]	50	34	75,000	75,000	100%
BOE:	Canarsie	18	7	7	0	6,631	6,631	100%
	Flatbush/ Brownsville	17	21[d]	21	0	24,500	24,500	100%
	East Harlem	4	20[d]	20	0	13,500	13,500	100%
SDOH:	East Harlem Council	4	6	5	1	3,612	2,405	66%
	Harlem Hospital	5	7	6	1	4,086	2,627	66%
	Hunts Point Multi-Service Center	7	5	3	2	2,819	1,558	55%
	Bronx Lebanon Consortium	9	5	5	0	4,817	2,965	62%
	Jamaica Hospital	27	8	5	3[b]	3,263	2,069	63%
	Lutheran Medical Center	15 & 20	6	4	2[c]	4,964	3,468	70%

a) In SDOH projects, enrollment figures show % of children registered in Levels 2 & 3.

b) includes 2 Headstart programs

c) includes 1 Headstart program

d) All schools in district(s) are receiving services.

Source: CCC Interviews with NYCDOH and BOE. SDOH project statistics are from: New York State Department of Health School Health Services Demonstration Summary Statistical Report, 12/82 - 2/83.

APPENDIX B

DESCRIPTION OF NEW YORK CITY DEPARTMENT OF HEALTH SCHOOL HEALTH PROGRAM

The New York City Department of Health (DOH) is the official provider of school health services to children attending the public and parochial schools in New York City. It has been the target of some criticism in recent years because of a reduction in the level of quality of services offered to children as a result of budget cuts.

In 1981 the DOH responded to this criticism by reorganizing the school health program through administrative changes and, more recently, by hiring additional staff. A new director was hired and the Bureau of School Health was centralized. Public health nurses now work exclusively for the school health program and report to the director of the program rather than to the DOH District Health Center nearest the school. Thirteen district nurse supervisors were reassigned to the program and have primary responsibility for a group of school districts and the schools within them.

A statement recently released by the City Health Commissioner states that the goal of the "new" program is to maintain and improve the health status of children in school by focusing on those activities that will result in detection and follow-up of problems that could "seriously affect a child's longevity, quality of life or ability to learn." The paper notes that the School Children's Health Program is not a substitute for a child's primary care provider. Rather, the program staff will follow up on problems and ensure that the child who needs care is linked to an appropriate source of care.*

The City Department of Health has four specific priorities for its school health program:

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*New York City DOH, "School Children's Health Program," July, 1982.

- Provision of complete physical examinations to all new students who have not received an examination from an outside provider;
- Follow-up care (including home visits if necessary) of all children who have had problems identified during physical examination;
- Teacher-nurse conferences in the second and fourth grade so the nurse can observe children in the classroom;
- Faculty conferences to alert teachers, principals and staff to the health care needs of children in the school and inform them about the services provided by the DOH.

CCC visited with the district supervising nurse in charge of Community School Districts 15 and 20 in Brooklyn to see how staff was allocated in one area and to discuss problems encountered in providing services. She is responsible for supervising the delivery of CDOH school health services in 84 schools in the two school districts: 50 public schools with approximately 55,000 children and 34 parochial schools with over 20,000 children. The staff providing services to these 75,000 children include: 8 full-time public health nurses (PHN), 1 part-time PHN, 2 full-time pediatric nurse associates (PNAs) and 6 public health assistants (PHAs). A supervising pediatrician and five other doctors (2 half-time and 3 quarter-time) also work in the district.

The public health nurses provide the follow-up. Unlike the doctors and the pediatric nurse associates, the public health nurses (PHNs) are assigned to and rotate among a specific group of schools. In CSD #15 and 20, each PHN visits approximately 13 schools and is responsible for providing follow-up of approximately 6,000 students. The nurses' schedules are regularized so that the school knows when the nurse is coming. Follow-up includes reviewing 103s charts to detect the need for further attention, referring the child to an outside provider, and occasionally doing home visits. (Approximately 361 home visits were done in CSD #15 and 20 between September 1982 and May 1983. 13,488 "follow-ups" were provided during that same period.) In addition to examinations and follow-up, 449 teacher-nurse conferences and 31 faculty

conferences were held between Spetember 1982 and May 1983.*

In the parochial schools in the district, the DOH staff have been concentrating on faculty and teacher-nurse conferences. Parochial schools do not have public health assistants. According to the district supervisor, the parochial schools need them less because the staff in the schools are more disciplined about maintaining medical records.

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* Source: DOH, School Health Program

APPENDIX C

DESCRIPTION OF THE BOARD OF EDUCATION DEMONSTRATION PROJECTS

Three different models are used to provide school health services in the Board of Education (BOE) projects. In CSD #18 in Canarsie, a middle-class area with approximately 19% of the school children on AFDC*, the project provides health services to 6,631 children in 7 public schools. The project employs 7 health aides - 1 in each school - and 1 nurse practitioner (NP) for the more than 6,000 students. The nurse practitioner supervises the aides, reviews charts, performs height, weight, vision and hearing screenings and provides follow-up. She also gives physical examinations to those few children who are unable to obtain them through community resources. A pediatrician - the medical preceptor - is considered the supervisor of the project but provides little more than consultation when the nurse practitioner needs assistance.

The demonstration project in CSD #17 in Brownsville, Brooklyn, furnishes school health services to approximately 24,500 children in all 21 public schools in the school district. Twenty-one health aides (1 per school) and five public health nurses (1 per 4,900 students) staff the project. It is the only demonstration project based on a collaborative model, using Department of Health doctors to provide examinations to these students who cannot afford to pay an outside provider. The student population in this district is predominantly black and poor, with approximately 52.4% of the children on AFDC.*

In CSD #4 in East Harlem,** 13,500 students in the 20 schools in the school district receive services provided by 20 health aides (1 per school), 4 nurse

*Source: BOE. Percentage of children per school district who receive Aid to Families with Dependent Children is the way in which the BOE measures poverty in the schools. Figures are from the 1981-82 school year.

**Some schools in East Harlem receive services from both the BOE project and a State DOH project. See Appendix F.

practitioners (1 per 3,375 students) and a half-time pediatrician who serves as supervisor. Nurse practitioners and the part-time M.D. provide examinations to new students and pre-high school students in this project. Students in CSD #4 are Hispanic and poor; approximately 67% of the students in the district are on AFDC.*

The BOE projects offer health services to children in public schools only. Service to parochial schools in these districts continues to be provided by the CDOH.

APPENDIX D

DESCRIPTION OF STATE DEPARTMENT OF HEALTH DEMONSTRATION PROJECTS

In New York City, there are State Department of Health funded demonstration projects in seven community school districts which receive health services from a range of Article 28 providers: four community health centers, two ambulatory care clinics in community hospitals and a consortium of community health centers which have been contracted with the SDOH to provide services to children in both public and parochial schools. The enabling legislation - Chapter 50 of the laws of 1981 - requires that all schools served be in high risk areas.*

Bronx: CSD #7 - Hunts Point

The Hunts Point Multi-Service Center (HP-MSC), a federally funded community health center located in Hunts Point in the Bronx, operates a State funded school health program in 3 public schools (IS 155, PS 57 and PS 161) and 2 parochial schools serving approximately 3,000 children in CSD #7. The neighborhood is predominately Hispanic. Three teams made up of 1 health aide and 1 mid-level practitioner** rotate among the schools visiting each public school 3 days a week, and each private school 2 days a week. A half-time pediatrician spends 3-1/2 hours at each school each week.

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*The SDOH examined the health status and socio-economic indicators to define the high risk areas of the city which could be served by demonstration projects. A matrix of those indicators has been developed to assist the SDOH in determining which districts should be served. See Appendix E.

**As used in the description of the State projects, mid-level practitioner refers to nurse practitioners or physician assistants whose responsibilities include physical examinations, treatment and provision of follow-up care.

Bronx: CSD #9 - South Bronx

The State demonstration project in CSD #9 provides primary care health services to 6,000 children enrolled in five public elementary schools (PS 55, 64, 73, 90 and 229) and one public intermediate school (IS 166) in the South Bronx. The children receive comprehensive services from 5 nurse practitioner-health assistant teams sponsored by a consortium of 5 community health centers which have collaborated to improve the delivery of health care services in the Bronx. The centers include:

- The Ambulatory Care Network of the Bronx-Lebanon Hospital
- The Martin Luther King, Jr. Health Center (a federally funded community health center)
- The Montefiore-Morrisania Comprehensive Health Care Center of the Montefiore Medical Center
- The Morrisania Neighborhood Family Care Center of the New York City Health and Hospitals Corporation
- The Morris Heights Health Center (a federally funded community health center).

Each school is linked with one health center.

This project has developed a health education component in which students are trained to become "Health Angels," a corps of fourth and fifth graders who teach their peers about health education.

Brooklyn: CSD #13 - Bedford Stuyvesant

The Lyndon B. Johnson Health Complex provides health services to approximately 4,000 students in this school district. Citizens' Committee for Children did not visit this project.

Brooklyn: CSD #15 and 20 - Sunset Park

In CSD #15 and 20, the Sunset Park Community Health Center at Lutheran Hospital provides comprehensive health services to approximately 5,000 children in a predominantly Hispanic neighborhood. The project serves students in 4 public elementary schools, 3 of them in CSD #15 and 1 in CSD #20. St. Michael's, a parochial elementary school with 375 children and a Headstart program with 180 children 3-5 years of age, also receive services.

The project staff includes 4 health aides and 4 mid level practitioners. Each mid level practitioner works with a family physician who comes into the school at least twice a week. The physicians are third-year family practice residents at Lutheran Medical Center.

There is a full-time dental hygienist providing dental screenings and referrals to the children in the program. In addition, a psychologist offers short-term counseling in the school for students who are referred by teachers and provides long-term counseling at the Sunset Park Health Center site.

Manhattan: CSD #4 - East Harlem

The East Harlem Council for Human Services (Boriquen Neighborhood Health Center) provides screening and direct treatment to approximately 3,000 children in 6 schools (5 public and 1 parochial) in one quadrant of the predominantly Hispanic East Harlem school district. Five teams of 1 health aide and 1 mid level practitioner (the staff includes 3 nurse practitioners and 2 physician assistants) work in the 6 schools. The supervising physician in the project visits each school once a week. The schools which are part of both the State and City projects have 2 health aides, a mid level practitioner in each school and the nurse practitioner from the BOE project providing backup services to the aides in these 6 schools. The children in the 6 State project schools have the opportunity to receive the comprehensive primary care, while the students in the BOE

project cannot be treated in the schools.*

Manhattan: CSD #5 - Central Harlem

The State Health Department demonstration project at Harlem Hospital provides health services to approximately 4,000 children in 7 schools in CSD #5: 2 public intermediate schools, 4 public elementary schools, and 1 parochial school (kindergarten through 8th grade). The staff includes 8 "community workers" (health aides - 1 in each school and 1 supervisor; 3 mid level practitioners (2 pediatric nurse practitioners and 1 physician assistant) who rotate among the schools and spend approximately 2-1/2 days at each school; and the equivalent of 1 half-time pediatrician. The project coordinator is a full-time pediatrician at Harlem Hospital and spends approximately 30% of her time in the project. A NYC DOH physician in private practice in Harlem provides backup to the Harlem project in addition to working 4 days per week in the Harlem schools as part of the NYC DOH school health program.

Queens: CSD #27 - Jamaica

The SDOH project sponsored by the Department of Ambulatory Care at Jamaica Hospital provides school health services to 3,237 children in 5 public elementary schools, 1 parochial school (K-8th grade) and 2 Headstart programs in CSD #27 in Jamaica, Queens. The population served by this program is approximately 90% black. Four nurse practitioners, 5-1/2 health aides, and 1 three-quarter time physician provide services to the children in this project. The physician is also on staff at Jamaica Hospital. There is 1 health aide in every school. Nurse practitioners rotate among schools, depending on the need. One of the nurse practitioners and a social worker providing counseling services are furnished by the National Health Services Corps program. Cuts in this federally funded program may affect the staffing levels in this project.

*See Appendix F.

APPENDIX E

STATE DEPARTMENT OF HEALTH TABLE USED TO DETERMINE WHICH SCHOOL DISTRICTS ARE "HIGH-RISK"

The State Department of Health developed the following matrix of indicators of community health status to assist it in determining which areas of New York City can be considered "high-risk" and should be served by the demonstration projects:

APPENDIX E

Community School District**		1980 % Fully Immunized	1978 Infant Mortality Rate Deaths/per 1000 children	1979 % Births to Mothers less than 19 yrs. of age	Hosp. Rate per 1000 Children 0-5 yrs. of age	1979 % Births less than 2500 gms.	% Free School Lunch Participation
Manhattan	1	53.1	15.7	14.4	144	8.8	68.8
	2	58.3	12.5	9.5	125	7.0	57.7
	3	54.3	15.5	11.5	140	10.8*	67.7
	4	42.8*	18.8	25.9*	188	12.4*	74.2*
	5	50.9	32.2*	22.5*	192	15.6*	68.4
	6	55.8	11.6	13.6	145	8.3	68.7
Bronx	7	45.6*	22.7*	27.8*	275*	11.3*	72.6*
	8	78.7	16.6	12.9	214*	8.6	70.3*
	9	47.1*	20.9*	22.9*	207*	12.2*	69.2
	10	51.2	13.7	14.0	190	9.1	67.4
	11	46.4*	14.4	12.5	163	9.5	55.1
	12	51.0	14.7	24.7*	180	10.6*	75.8*
Brooklyn	13	45.5*	25.4*	20.1*	162	12.3*	74.4*
	14	46.9*	15.5	17.4	162	8.1	79.4
	15	50.8	22.7*	17.5	180	12.6*	68.6
	16	43.9*	24.5*	28.3*	209*	8.7	71.2*
	17	49.8*	17.8	12.1	162	9.6	72.2*
	18	50.1	10.9	7.3	151	8.4	51.5
	19	48.7*	17.1	22.4*	138	10.9*	65.2
	20	45.6*	16.5	12.8	195	9.0	45.9
	21	41.6*	12.3	7.7	145	6.6	49.0
	22	48.5*	12.2	6.7	136	7.1	39.1
	23	44.6*	17.1	26.3*	173	14.7*	73.0*
	32	48.0*	13.1	13.9	306*	7.0	73.7*
Queens	24	45.2*	12.8	7.3	137	6.6	53.8
	25	44.9*	12.5	4.0	111	5.8	26.0
	26	48.2*	7.3	3.0	121	5.6	Unk.
	27	45.6*	14.6	13.7	169	8.0	53.7
	28	45.1*	10.5	9.6	141	7.5	51.1
	29	47.5*	18.2	17.1	148	10.7*	52.3
	30	50.7	12.1	9.0	125	7.6	55.5
		* = <50%	* = > 20/1000	* = > 20%	* = > 200/1000	* = > 10%	* = > 70%

52

** Public Schools, through Jr. High, only.

53

APPENDIX E

School Districts high on 4 or more of the 6 indicators

	CSD
Manhattan	4
Bronx	7
	9
Brooklyn	13
	16
	23

School Districts high on 3 or more of the 6 indicators

Manhattan	4
	5
Bronx	7
	9
	12
Brooklyn	13
	16
	19
	23
	32

APPENDIX F

MEMORANDUM ON DIFFERENCES BETWEEN CITY AND STATE PROJECTS
IN COMMUNITY SCHOOL DISTRICT #4

(Office of the Community Superintendent, District #4
Mr. Anthony Alvarado, Community Superintendent)

M E M O R A N D U M

TO: Principals at PS 7, 96, 112, 155, 206 and JHS 45
FROM: Luis Jimenez, M.D.
Supervising Physician

****

Below are noted the essential differences between the Chancellor's Demonstration Project and the State Demonstration Project of the East Harlem Council for Human Services (EHCHS).

Chancellor	EHCHS
1) Screening - all grades. Examinations - only new entrants and pre-high schools.	1) Screening & Examinations - only beginning of 3rd, 6th and 8th grades, new school entrants, entrance into the program; a) full medical history b) hematocrit c) urinalysis d) tuberculin skin tests e) sickle cell screening f) neuro development evaluation g) give immunization.
2) Referring only of medical conditions.	2) Diagnosing and treating medical conditions.
3) Initiating and transferring medical records.	3) Making entries only on medical records.

If you have any questions please don't hesitate to call Ms. Courtney Collins, PNP, (860-6024) or myself at 860-6021.

LJ/srm
cc: David L. Schroedel

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